

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address Lisa R. Reznick, M.D. 751 Hebron Parkway #230 Lewisville, TX 75057	MDR Tracking No.: M4-03-7685-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address St. Paul Fire & Marine Insurance Co. Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.: WVK9101821 09W020

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/30/03	04/30/03	99080-69	\$15.00	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a Position Summary; however, the requestor's rationale, which was addressed on the table of disputed services, states, "I am the treating MD for this patient and performed a MMI and Impairment Ration as well as completed the TWCC-69 form. As the treating MD, I should be paid for the TWCC-69 form".

## PART IV: RESPONDENT'S POSITION SUMMARY

The respondent's Position Summary dated 07/07/03 states in part, "...This is a fee dispute involving retrospective medical necessity. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier asserts that the charges are inconsistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines..."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 99080-69 for date of service 04/30/03 denied as "G – Unbundling." Per the 1996 Medical Fee Guideline, E&M Ground Rule (XXII)(D)(1)(c) the preparation and submission of reports is inclusive to the MMI/IR; therefore, reimbursement is not recommended.

**PART VI: DETAIL FINDINGS (If needed)**

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
4/30/2003	99080-69	\$15.00	\$0.00				
				Total Left Column:			\$15.00
				Total Amount Due:			\$0.00

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

Marguerite Foster 1-13-05

Authorized Signature	Typed Name	Date of Order
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## PART VIII. YOUR RIGHT TO REQUEST A HEARING

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## PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_